THE PRACTICAL THEORIST 8

DANGEROUS CONSEQUENCES:
Understanding the Link Between Substance Abuse and HIV/AIDS

A PUBLICATION OF
COMMUNITY ANTI-DRUG COALITIONS OF AMERICA (CADCA)

SUPPORTED IN PART BY THE
NATIONAL INSTITUTE ON DRUG ABUSE (NIDA),
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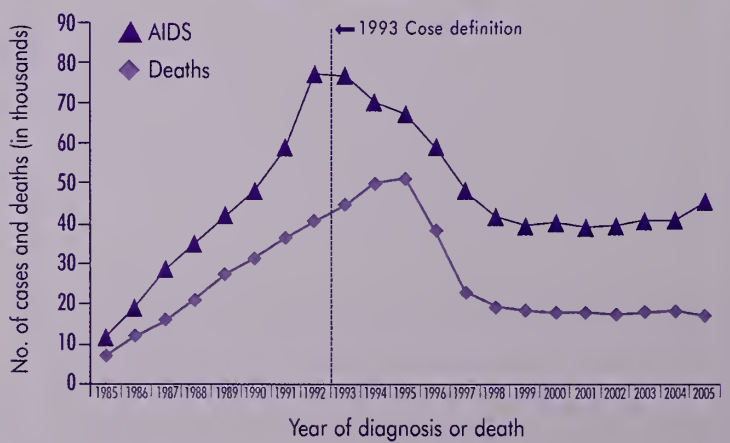
INTRODUCTION

An estimated 1 million people in the United States are living with HIV/AIDS. In this country, annual reported AIDS cases peaked in 1993 at approximately 80,000. While declining steadily between 1993 and 1998, since 2001 the incidence of new AIDS cases has increased slightly each year, with approximately 42,500 new cases reported in 2004.

Early in the HIV/AIDS epidemic, infections were mainly seen among White, urban, men who have sex with men (MSM) or male injecting drug users (IDUs). Today, however, more people have come to recognize the important role non-injection drug abuse plays in the spread of HIV and AIDS through the dangerous risk behaviors it engenders. Drug and alcohol intoxication affect judgment and can lead to risky sexual behaviors that put people in danger of contracting or transmitting HIV.

Estimated Number of AIDS Cases and Deaths among Adults and Adolescents with AIDS, 1985–2005—United States and Dependent Areas



Note: Doto hove been adjusted for reporting deloys
Source: Centers for Disease Control and Prevention

In fact, an emerging trend in HIV infection is a rise in new infections among MSM after experiencing a substantial decline. This increase has been associated with many factors, including a resurgence of risky sexual behavior linked to the use of methamphetamine and other club drugs.

To help coalitions better address HIV/AIDS in their communities, Community Anti-Drug Coalitions of America (CADCA) in collaboration with the National Institute on Drug Abuse (NIDA) have developed **"Dangerous Consequences: Understanding the Link Between Substance Abuse and HIV/AIDS."**

This publication, the 8th in CADCA's *Practical Theorist* series, provides an overview of the impact of substance abuse on HIV/AIDS. It summarizes the latest research regarding the linkages between infectious disease and substance abuse and highlights real-life examples of how local coalitions in Detroit, MI; Berks County, PA; and Atlanta, GA are addressing this issue.

HIV/AIDS AND DRUG ABUSE

Drug abuse has been linked with HIV—the virus that causes AIDS—since early in the epidemic. Using or sharing unsterile needles, cotton swabs, rinse water, and cookers, such as when injecting heroin, cocaine, or other drugs, leaves a drug user vulnerable to contracting or transmitting HIV.

And, while intravenous drug use is well known in this regard, less recognized is the role that drug abuse plays more generally in the spread of HIV by increasing the likelihood of high-risk sex with infected partners. The intoxicating and addictive effect of many drugs can alter judgment and inhibition and lead people to engage in impulsive and unsafe behaviors.

Drug abuse and addiction can also worsen the impact of HIV. It can affect treatment adherence to HIV medications and it may affect the replication of the virus, thereby influencing the course of the illness. Drug abuse can worsen the consequences of HIV in the brain—methamphetamine abusers infected with HIV suffered greater neuronal injury and cognitive impairment than non-drug users.

What are the statistics?

From 2000 to 2004, almost 60,000 AIDS diagnoses in the United States were due directly to injection drug use, with males accounting for nearly 72 percent of these cases. Over this same period of time, there has been a gradual decline in the number of new AIDS diagnoses associated with injection drug use for both males and females.

Among racial and ethnic groups, as of 2004, 41 percent of cumulative AIDS cases reported among adult and adolescent Hispanic males in the United States were directly or indirectly related to injection drug use, as were 42 percent among African-American males.

The percentages were greater among females. Fifty-six percent of cumulative AIDS cases reported among adult and adolescent Hispanic females were directly or indirectly related to injection drug use, as were 55 percent of cases reported among White females and 49 percent among African American females.

We do not have equivalent statistical information regarding the role of noninjection drug use in the spread of HIV/AIDS. However, one CDC study of more than 2,000 young adults in three inner-city neighborhoods found that crack smokers were three times more likely to be infected with HIV than non-crack smokers.

Did You Know?

- Drug and alcohol intoxication affect judgment and can lead to risky sexual behaviors that put people in danger of contracting or transmitting HIV.
- In 2004, nearly 5,000 young people were diagnosed with HIV/AIDS.
- Teens and young adults account for approximately half of the 19 million new cases of sexually transmitted infections diagnosed each year.

SECTION 2

POSITIVE IMPACT OF DRUG TREATMENT

Since the late 1980s, research has shown that drug abuse treatment is effective HIV prevention. Drug abusers engaged in treatment have a higher likelihood of stopping or reducing their drug use and related risk behaviors, including risky injection practices and unsafe sex. This is particularly true when treatment is combined with HIV prevention and community-based outreach programs for at-risk people.

Drug abuse treatment programs can serve an important role in providing current information on HIV/AIDS and related diseases, counseling and testing services, and referrals for medical and social services.

Combined pharmacological and behavioral treatments for drug abuse have a demonstrated impact on reducing HIV risk behaviors. For example, when behavioral therapies were combined with methadone treatment, approximately half of study participants who reported injection drug use at intake reported no such use upon exiting the study, and over 90 percent reported no needle sharing at the end of the study.

Drug abuse treatment has also been shown to decrease cocaine use from an average of 10 days per month at baseline to one day per month at 6-month follow up among non-injection cocaine abusers. Reduction in cocaine use was associated with an average 40 percent decrease in HIV risk across gender and ethnic groups, mainly as a result of fewer sexual partners and less unprotected sex. Among MSM who abused methamphetamine, comprehensive behavioral treatment reduced risky sexual behaviors and sustained those reductions for at least one year following treatment.

Behavioral treatments have also shown promise for enhancing adherence to antiretroviral therapy. HIV treatment adherence is vital to treatment success, but can require dramatic lifestyle changes. Effective HIV treatment includes providing a consistent medical regimen to counter the often chaotic lifestyle created by drug abuse and addiction.

Drug treatment programs can also help to reduce the spread of other blood-borne infections, including hepatitis B and C viruses.

Research from NIDA has shown that comprehensive HIV prevention strategies, including community-based outreach, testing and counseling for HIV and other infections, can be cost-effective and reliable in preventing

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new HIV infections among diverse populations of drug abusers and their communities. Short of a vaccine or cure for AIDS, preventing the spread of the virus is the most cost-effective approach. Research has demonstrated that school and community-based drug-abuse prevention programs designed for inner-city African-American boys can be effective in reducing high-risk behaviors, including drug abuse and risky sexual practices that can lead to HIV infection. The research also underscored the importance of incorporating cultural competency for specific populations.

What is Hepatitis C?

Hepatitis C is a disease of the liver caused by the hepatitis C virus (HCV). Eighty percent of infected individuals show no signs or symptoms. Symptoms that can appear include jaundice, fatigue, dark urine, abdominal pain, loss of appetite and nausea. Infection can lead to chronic liver disease in 70% of cases, which in 1%-5% of cases can result in death. Transmission of the virus can occur when the blood of an infected person enters the body of a person who is not infected. HCV is spread by sharing needles when injecting drugs, through needlesticks or sharp exposures on the job, or from an infected mother to her baby during birth. Most infections are due to illegal injection drug use. An estimated 4.1 million Americans (1.6%) have been infected with HCV, of whom 3.2 million are chronically infected. The number of new infections per year has declined from an average of 240,000 in the 1980s to 26,000 in 2004. There is no vaccine to prevent HCV. The virus is detectable by a blood test.

Early detection of HIV is another cost-effective approach. Research indicates that routine HIV screening in healthcare settings among populations with an infection prevalence rate as low as 1 percent is as cost effective as screening for other conditions such as breast cancer and high blood pressure. These findings suggest that HIV screening can lower healthcare costs by identifying infection, providing a venue for risk-reduction counseling, and providing referral for appropriate medical follow-up to reduce HIV-associated morbidity.

Buprenorphine is playing a key role in getting more opiate-addicted patients engaged in drug abuse treatment. According to the Substance Abuse and Mental Health Services Administration, nearly 105,000 patients had been treated with buprenorphine by March 2005. An overwhelming majority of patients have found buprenorphine helpful (99 percent) and 97 percent would recommend buprenorphine to a friend suffering from opioid addiction. Buprenorphine was approved for treating opioid addiction by the U.S. Food and Drug Administration in October 2002.

A recent study found that 59 percent of buprenorphine patients were still abstinent from all drugs six months later, while 81 percent were abstinent from opioids. Buprenorphine also exhibits high treatment retention rates. Notably, needle sharing among a patient sample receiving buprenorphine dropped from 5 percent at baseline to 1 percent at 30-day follow-up and 2 percent at six-month follow-up. Patients with more than one sex partner dropped from 7 percent at baseline to 6 percent at 30-day follow-up and 0 percent at six-month follow-up.

SECTION 3

PRINCIPLES OF HIV PREVENTION

A research based guide developed by NIDA lists 17 principles of HIV prevention in drug-using populations. The guide is available online at http://www.drugabuse.gov/POHP/.

NIDA's 17 principles of HIV prevention are:

1. Reducing the risk of transmitting and /or acquiring HIV/AIDS among drug users is an achievable goal.
2. A community should start HIV/AIDS prevention programs as soon as possible.
3. Effective prevention programs require a comprehensive range of coordinated services.
4. Prevention programs should work with the community to plan and implement interventions and services.
5. Prevention programs must be based on a thorough, continuing assessment of local community needs, and the effectiveness and impact of these programs should be continually assessed.
6. Prevention services can most effectively reach drug-using populations when they are available in a variety of locations and at a range of operating times.
7. Prevention and treatment efforts should target both HIV+ and HIV- drug users, as well as their sex partners.
8. Prevention efforts should target not only individuals, but also couples, social networks, and the broader community of drug users and their sex partners.
9. Community-based outreach should be directed toward drug users in their own neighborhoods.
10. Prevention interventions should be personalized for each person at risk.
11. Drug users and their sex partners should be treated with dignity and respect and with sensitivity to cultural, racial/ethnic, age, and gender-based characteristics.
12. As part of a comprehensive HIV prevention program, injection drug users should have ready access to sterile

What is the Highly Active Antiretroviral Therapy (HAART) Protocol?

The availability of the HAART medication protocol for HIV/AIDS patients since 1996 has changed the face of the disease. HAART is a customized combination of different classes of medications that a physician prescribes based on such factors as the patient's viral load, CD4 lymphocyte count, and clinical symptoms. HAART controls viral load, helping to delay the onset of symptoms and achieve prolonged survival in people diagnosed with HIV/AIDS.

A challenge for patients treated with HAART is adhering to their medication regimen. This can be particularly problematic for drug abusers with chaotic lifestyles. In addition, because HAART reduces viral load, some patients mistakenly believe that they do not need to adhere to the treatment regimen or that a reduced viral load eliminates the risk of transmitting HIV. This can lead to complacency about risk behaviors and resumption of unsafe sex and injection practices.

injection equipment to reduce their use of previously used injection equipment.

13. Interventions that target injection risk should address sharing other injection equipment in addition to syringes.

14. Risk reduction information alone is often not enough to help drug users and their sex partners make lasting behavioral changes.

15. Prevention efforts should address the risks of transmitting HIV and other infections sexually as well as through drug injection.

16. HIV/AIDS risk-reduction interventions should be sustained over time.

17. Community-based prevention is cost-effective.

PSAs Available About Drug Use and HIV/AIDS

Public service announcements (PSAs) are an effective way to spread the word about the risks associated with alcohol and drug use. Several PSAs are available on NIDA's Web site that can help increase awareness about substance abuse and HIV/AIDS. The PSAs, available in 15-second, 20-second, 30-second and 60-second spots, can be sent to public service directors at both radio and TV media stations. For more information, visit http://hiv.drugabuse.gov/media.html.

Effective prevention programs require a comprehensive range of coordinated services.

SECTION 4

PREVENTING HIV/AIDS IN DRUG USERS

Given the diversity of drug users and their sex partners, no single HIV/AIDS prevention strategy will work effectively for everyone. A comprehensive approach that readily adapts and responds to changing patterns of drug use and HIV/AIDS risk behaviors, the characteristics of local settings, and the varied service needs of drug users and their sex partners is the most effective strategy.

WHAT ARE THE COMPONENTS OF A COMPREHENSIVE HIV/AIDS PREVENTION APPROACH?

Research has shown that a comprehensive HIV/AIDS prevention approach includes three complementary approaches: **community-based outreach, drug abuse treatment,** and **sterile syringe access programs.** Each of these approaches should include HIV testing and counseling and referral for appropriate medical care.

Community-based outreach relies on coalitions and other grassroots leaders who typically reside in the local community and are familiar with its drug use subculture. They are in a unique position to educate and influence their peers to stop using drugs and reduce their risks for HIV and other blood-borne infections.

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Effective drug abuse treatment helps prevent HIV. Drug users who enter and continue in treatment are more likely than those who do not to reduce risky activities such as sharing needles and injection equipment or engaging in unprotected sex. Drug abuse treatment can be conducted in a variety of settings (inpatient, outpatient, residential), can consist of various approaches, including behavioral therapy, medications, or a combination of both, and should include HIV testing, counseling, and appropriate referral for medical follow-up.

EFFECTIVENESS OF THESE APPROACHES

The effectiveness of community-based outreach has been shown through 15 years of research on HIV/AIDS prevention interventions. Cumulative research from a 23-site study that followed 18,144 drug users (13,164 IDUs and 4,980 non-injecting crack users) showed that 3 to 6 months after participating in a community outreach intervention, 72 percent of the IDUs either stopped injecting drugs or reduced their frequency of injection. Of those who continued to inject, nearly 60 percent either stopped or reduced reusing or sharing their syringes. Twenty-six percent of crack cocaine

users had stopped using crack cocaine at follow-up. Nearly 25 percent of participants in the study had entered treatment at follow-up, many for the first time.

Studies have consistently shown that drug abuse treatment is associated with lower rates of drug injection. A three-year study of drug use patterns among male IDUs participating in methadone maintenance treatment reported that 71 percent of 388 patients who had remained in treatment for one year or more had stopped injecting drugs. Conversely, in a second group of 105 IDUs who had dropped out of treatment, 82 percent had relapsed to injecting drug use within a year. Another study found that opiate addicts who were recruited by street outreach workers and offered free methadone maintenance treatment were significantly more likely to enter and remain in treatment even if they had never been in treatment before or claimed not to want treatment.

By preventing HIV infections, community-based interventions help avert future medical costs associated with the care and treatment of HIV/AIDS.

ROLE OF COMMUNITY-BASED LEADERS

Community-based leaders, such as coalition directors and staff, are on the front line in the local community and they know where, when, and how to contact even the most difficult-to-reach drug users in their neighborhoods. They are a trusted and recognized source of information and can help drug users understand their personal risks for HIV and other blood-borne diseases and identify preventive steps they need to take. As a peer, community leaders can encourage drug users to stop or reduce their using and injecting drugs and enter drug abuse treatment. They are a vital link to education and can provide referrals for HIV testing, treatment, and counseling and other health, prevention, and social service programs.

COST-EFFECTIVENESS OF HIV PREVENTION

Cost-effectiveness studies have reported that, by preventing HIV infections, community-based interventions help avert future medical costs associated with the care and treatment of HIV/AIDS. Drug abuse treatment programs are also cost-effective in reducing drug use and associated health and social costs, especially when compared to not treating addicts or incarcerating them.

NIDA'S COMMUNITY-BASED OUTREACH MODEL

NIDA's Community-Based Outreach Model is based on more than fifteen years of NIDA-funded research and has been tested in 52 communities with more than 60,000 injection drug users, 14,000 crack users, and many of their sex partners. The model has been used and tailored to the needs of specific at-risk subgroups and has been found to be effective with multiracial, multiethnic, male and female, HIV seropositive and seronegative, infected and non-infected drug-using populations residing in low, medium, and high HIV prevalence.

NIDA's Community-Based Outreach Model includes two interrelated components designed to facilitate behavior change among at-risk drug users. These include (1) community–based outreach and (2) two sessions of education and risk-reduction counseling that are organized around testing for HIV, hepatitis B virus (HBV), and hepatitis C virus (HCV), to provide pre-and post-test counseling to help drug users learn their serostatus and the behavior changes needed to reduce transmission risks.

In addition to accessing drug users in a variety of community settings, outreach workers serve as role models, educators and advocates who can provide drug users with changing and accurate risk-reduction information in settings that are familiar to them and at times of greatest risk.

Specific outreach strategies include: communicating basic risk-reduction information; presenting a hierarchical framework for understanding the relative effectiveness of different risk-reduction strategies; providing literature and other materials to support behavior change; facilitating access to drug treatment, HIV/AIDS testing and counseling services, and other medical and social services available in the local community.

The two sessions of individual HIV risk-reduction counseling can be held within the context of outreach contacts or can be conducted in an office setting, either by outreach workers or other staff (counselors, health educators). The first session provides basic information about the transmission and prevention of HIV, HBV, HCV, and other sexually transmitted diseases, addressing sexual transmission and drug injection risks. The second session provides both a review of risk-reduction information and the opportunity to reinforce and support behavior change efforts. The sessions are designed to occur before and after HIV testing, which can be provided directly as part of a prevention program or indirectly by means of a referral.

Effective HIV/AIDS prevention requires a range of coordinated services. The NIDA Community-Based Outreach Model is designed to complement other prevention strategies, including HIV prevention case management, drug abuse treatment, and access to sterile syringes through pharmacies or syringe exchange programs. Because multiple providers will no doubt be involved in the delivery of services, careful attention must be given to the coordination of services within a community.

The NIDA Community-Based Outreach Model is intended to be customized by local communities. This customization will depend on a careful assessment of local community needs. There is considerable variation across communities in the nature and extent of drug use, the prevalence and course of HIV/AIDS, patterns of risk-taking and the availability of community resources. Resource limitations may necessitate that prevention efforts be focused to reach those at greatest risk. Ongoing surveillance of local drug use and HIV risk-behavior patterns provide important information for identifying new populations at risk and tailoring the content of prevention messages.

Because of their familiarity with the drug-use subcultures and local neighborhoods in their communities, outreach workers can access out-of-treatment drug users in their natural environments, including the streets, storefronts, parks, shooting galleries, crack houses, soup kitchens, homeless shelters, abandoned buildings, and syringe exchange programs. Using a converted recreation vehicle or van as a mobile home-base for outreach activities when targeting such places can be an effective means of reaching at-risk populations.

To download NIDA's Community-Based Outreach Model, go to http://www.drugabuse.gov/CBOM/Index.html.

COALITIONS IN ACTION

Detroit Coalition Educates Minority Community About Drug Use and HIV/AIDS

The Empowerment Zone Coalition (EZC), a 10-year old anti-drug coalition in Detroit, has brought together various community entities to get the word out on substance abuse and HIV/AIDS.

The EZC recently received a $25,000 grant from the Substance Abuse and Mental Health Services Administration to create and execute a substance abuse and HIV/AIDS education and awareness campaign in minority neighborhoods. The campaign will include a strong faith-based component. The EZC is a collaboration of dedicated individuals, grassroots community organizations, schools, churches, businesses, clubs and law enforcement agencies.

As part of its strategy to develop a successful campaign, the EZC has created a Community Advisory Council, comprising coalition members, providers of substance abuse treatment and prevention services, providers of HIV/AIDS services, the faith-based community, and other stakeholders. The CAC will oversee the development of the campaign. The CAC has sought to ensure that the campaign targets needs and concerns that exist in the community by organizing a public forum on substance abuse and HIV/AIDS.

"The goal of the public forum is not only to educate the community but to gain feedback on the impact that substance abuse and HIV/AIDS has specifically on our Detroit population," says Doreen Turk-White, executive director of EZC. "And, from that feedback, create compelling public service announcements that will help to change dangerous behaviors."

The goal is to have the community help to create the public education campaign. "In order for us to make sure we effectively address the issues that are going on in the community, we need to hear from the community, says Turk-White. "Often, we are far-removed from what's going on directly in the community."

Once the campaign is out there, the EZC will continue to disseminate information to service providers who are in the field and on the ground doing the work, says Turk-White. "Our main goal is to get people to abstain from drug use, but when they don't abstain they need to be more aware of the precautions and safeguards they need to take to protect themselves [and others]," says Turk-White. She believes the faith community does a great job of getting people to change the attitudes and social norms.

The EZC has done public service announcements and used the media to spread the word about the public forum and the public education campaign. They will also disseminate a list of resources that includes testing and counseling services. The EZC has leveraged the campaign by securing additional financial support for the campaign from area businesses.

For more information about the Empowerment Zone Coalition, call (313) 921-9403.

POPULATIONS MOST AFFECTED

African-Americans experience striking disparities in HIV-infection rates compared with other populations, and they are at a particularly high risk for developing AIDS. While African-Americans make up just 13 percent of the U.S. population, they accounted for more than half of the total AIDS cases diagnosed in 2004. Moreover, African-American females accounted for 68 percent of the female HIV/AIDS diagnoses from 2001 through 2004 while White females accounted for 16 percent and Hispanic females 15 percent. And although African-Americans ages 13-19 represent only 15 percent of U.S. teenagers, they accounted for 66 percent of new AIDS cases reported among teens in 2003.

By the end of 2004, an estimated 178,000 African-Americans were living with AIDS, the highest proportion of any racial/ethnic group. African-Americans represent 43 percent of AIDS cases diagnosed in the United States since the start of the epidemic. HIV/AIDS is now the leading cause of death among all African-Americans ages 25-44. The disproportionate rate of HIV infection among African-Americans is not due to higher rates of injection drug use or addiction in this population. Recent research suggests that African Americans have lower rates of drug or alcohol abuse or dependence, and African Americans and Whites do not differ significantly in their rates of injection drug use. The noted disparity may in part reflect data showing that African-Americans are predominant among those who become aware of their infection at later stages in the disease process and who therefore represent lost opportunities for early treatment. Screening for HIV through improved counseling and testing opportunities and referral to care is critical to reducing HIV/AIDS morbidity and mortality as well as further transmission.

According to the CDC, an estimated 40,000 young people (ages 13 to 24) in the United States have been diagnosed with AIDS. The number represents approximately 4 percent of the cumulative AIDS cases through 2004. Between 2000 and 2004, the proportion of young people diagnosed with AIDS increased from 4.3 percent to 5.1 percent. Risk factors for this age group include sexual experimentation and drug use, which are often influenced by peer group relationships and diminished parental involvement that can occur during adolescence. Compounding adolescent vulnerability today is the notion of "generational forgetting," a diminished view of the dangers of HIV/AIDS among certain members of today's generations. Studies show that today's youth may be more likely to hold this view than older Americans who witnessed a higher AIDS mortality rate associated with the rapid progression from HIV to AIDS early in the epidemic, prior to the availability of effective HIV treatment.

COALITIONS IN ACTION

Berks County, Pa. Coalition Leaders Take Lead on HIV/AIDS Prevention

In Berks County, Pennsylvania, the Community Prevention Partnership of Berks County has been using a holistic approach to educate Latino women about HIV/AIDS risks they may face.

The county has experienced an increasingly high incidence of both IV drug use (heroin) and HIV infection among its Hispanic residents. In response to this, the Community Prevention Partnership received funding from the Substance Abuse and Mental Health Services Administration to support the development and implementation of the Neighborhood Unity Program, an outreach and educational initiative targeting Hispanic women.

"These are women that have one partner and are not doing drugs but their partners may infect them with HIV because they're doing drugs and/or having unprotected sex with other people," says Mirla Otero, director of Latino and Community Services, Community Prevention Partnership of Berks County (Reading, Pa.). "These women think they're not at risk for getting HIV/AIDS or that substance abuse is not going to hurt them - our goal is to make sure that they understand that they're at risk," she says.

The prevention partnership provides 12 classes, one hour educational one hour social. They start by teaching women about their bodies. "We educate them about drugs and alcohol, how to use condoms, and how to protect themselves," Otero said. They also provide parenting education and encourage women to take an active role in their families' health, so that they can be the main source of information for their children and teens.

Women that attend seven classes or more graduate from the program and then are given a chance to take four more classes to become part of a women's health council, where they are trained to train others. Members of the women's health councils become leaders in the communities. They provide educational health sessions for different community groups, help out at testing sites, and help spread the word in the community about positive health behaviors.

The social aspect of the 12 classes is focused on allowing women to get to know each other and network among themselves.

The initiative is very important because Latina women are disproportionately affected by HIV/AIDS. Also, by preparing women to train others, the intervention is reaching their families and communities.

Otero says that even six months after the training ends, the women are retaining the information they were taught in the classes. They also are more likely to get tested. Otero hopes that this program becomes a model program.

COALITIONS IN ACTION

Georgia Coalition Increases Community Awareness About HIV/AIDS

Founded as a coalition of faith-based leaders, The Genesis Prevention Coalition in Atlanta, GA knew from the very beginning that they wanted to do something to address HIV/AIDS in Fulton and Cobb counties, which have two of the highest incidence rates of HIV/AIDS rates in Georgia. That's why, HIV/AIDS prevention was incorporated into the coalition's community drug prevention plan since the inception of the coalition in the mid-1990s.

"HIV/AIDS is part of all of our efforts around substance abuse," says Gwendolyn Brown, the chief executive officer of The Genesis Prevention Coalition. "It's part of our strategy – it's interwoven in all of our messages." The coalition works with their partners on several strategies around HIV/AIDS and other sexually transmitted diseases.

These strategies include HIV testing and counseling referrals to partners in the coalition, and case management and medical services for those who need it, says Brown. The coalition also runs risk reduction workshops, public service announcements to heighten awareness, and trains adult and youth facilitators to provide peer education workshops and presentations.

"They are all culturally appropriate and gender-specific around behavior changing with prevention messages," says Brown.

Coalition partners that receive testing and counseling referrals include the Fulton County Department of Health, AID Atlanta, which provides education and support services for people living with HIV, and the Cobb County Prevention Alliance, says Brown.

Overall, the Genesis Prevention Coalition works with 49 coalition partners throughout the Atlanta area. Many of the partners have outreach components to their programs. "There is a mixture between treatment, counseling, and testing," says Brown.

Coalition partners are also conducting educational workshops and training in churches, either at the pulpit or through workshops delivered on a regular basis, says Brown. "The faith-based community, of which we are part, is having its challenges—often discussion of AIDS is still hidden," says Brown. "We do some of the training and also train trainers in the different churches so that they can facilitate their own training."

AID Atlanta is a major training resource for the coalition partnership, says Brown, adding that the Genesis Prevention Coalition is in the process of conducting studies to determine the direct impact of their efforts.

To learn more about The Genesis Prevention Coalition, visit www.genesiscoalition.net.

CONCLUSION AND RESOURCES

Community coalitions can take concrete steps toward creating and implementing an effective substance abuse/HIV prevention framework. Research shows that drug abuse treatment is effective HIV prevention. This is particularly true when treatment is combined with prevention and community-based outreach programs for at-risk people. Community-based outreach programs rely on indigenous workers who act as peers and information providers to drug users at risk for HIV/AIDS.

NIDA's 17 principles of prevention in drug-using populations can help coalitions effectively incorporate HIV prevention in their community approach. The 17 principles focus on targeting drug users in their own neighborhoods, personalizing interventions for each person at risk, treating drug users and the sex partners with dignity and respect with sensitivity to culture and gender-based characteristics, focusing on enhancing individuals' motivation to change their risky behaviors, and offering sustained and repeated interventions. By following NIDA's Community-Based Outreach Model and adhering to the 17 principles, coalitions and other grassroots organizations can help stop the spread of HIV/AIDS in their communities.

RESOURCES ON DRUG USE AND HIV/AIDS

- **National Institute on Drug Abuse (NIDA)**
  www.drugabuse.gov
- **Substance Abuse and Mental Health Services Administration**
  www.samhsa.gov
- **Centers for Disease Control and Prevention**
  www.cdc.gov
- **Community Anti-Drug Coalitions of America (CADCA)**
  www.cadca.org
- **Health Resources and Services Administration**
  www.hrsa.gov
- **National Library of Medicine**
  www.nlm.nih.gov
- **Johns Hopkins AIDS Service**
  www.hopkins-aids.edu
- **Treatment Improvement Exchange**
  www.treatment.org
- **HIV InSite**
  http://hivinsite.ucsf.edu.

About the National Institute on Drug Abuse (NIDA)

NIDA's mission is to lead the Nation in bringing the power of science to bear on drug abuse and addiction. NIDA, a part of the National Institutes of Health, U.S. Department of Health and Human Services, supports the majority of the world's research on the health aspects of drug abuse and addiction. The agency's supported science addresses the most fundamental and essential questions about drug abuse, ranging from molecules to managed care, and from DNA to community outreach research.

About Community Anti-Drug Coalitions of America (CADCA)

CADCA's mission is to build and strengthen the capacity of community coalitions to create safe, healthy and drug-free communities. The organization supports its members with technical assistance and training, public policy, media strategies and marketing programs, conferences and special events.

This *Practical Theorist* is part of a series of publications designed to summarize field research on key drug abuse issues, and to present it in a concise, practical format, with strategies for using the data to mobilize communities and support your coalition's mission.

This publication is produced by CADCA. For questions, contact:

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